APS Healthcare

MEDICAID

Traumatic Brain Injury Waiver Services

Prior Authorization Cover Sheet

Agency Name: _____

Agency Address: _____

Provider Number: _____

Contact Person: _____

Telephone Number: (__ __ __)__ __ __-__ __ __ __

Member Name: _____

Medicaid Number: _____

Submission Date ____/_____/_____

	Total Units per month Previously approved	Total Units Requesting per month	Service Period for this request	Total Number of Units for this period
Case Management **T1016UB**			**FROM:** **TO:**	
Personal Attendant Services **S5125UB**			**FROM:** **TO:**	
Cognitive Rehabilitation Therapy **97532UB**			**FROM:** **TO:**	
Transportation **A0160UB**			**FROM:** **TO:**	

Submit to: APS Healthcare, Inc. at 1.866.607.9903

Please note:

If form is not correctly completed, it will be returned for completion. For purposes of new format changes, please submit the information listed below:

I. A copy of this cover sheet;
II. A copy of signed Service Plan;
III. Current Member Assessment; and
IV. Any other information that you feel will help justify your request.